Insurance and Real Estate Committee
PUBLIC HEARING
Thursday, March 17, 2022

Connecticut Association of Health Plans
Testimony Regarding

H.B. No. 5447 AAC PRIOR AUTHORIZATION FOR HEALTH CARE PROVIDER SERVICES.

Respectfully, the Connecticut Association of Health Plans would like to flag H.B. 5447 for future input from the health insurance industry. As currently drafted, the bill simply provides for a study and recommendations for what's known as "gold carding" whereby providers who have a certain rate of prior authorization approval would be exempted from prior authorization requirements. Given the propensity for reporting bills to be further amended with substantive language, particularly during a short session, we would like to request for the record an opportunity for continued dialogue should such a situation arise.

While "gold carding" may sound reasonable, it has repeatedly been shown to produce only temporary behavior change. A study published in The New England Journal of Medicine found that when incentives were removed for physicians in primary care practices in the United Kingdom, there were immediate reductions in documented quality of care across 12 indicators. Conversely there was little change in performance on the six quality measures for which incentives were maintained. This indicates that practices such as "gold carding" have challenges with encouraging and sustaining long-term positive behavior change. The data has demonstrated that when "gold carding" practices are in place, utilization – and accompanying costs –actually run higher because there are no cost management tools such as prior authorization.

By way of background, one large plan reports that nearly 100,000 requests are processed daily. 70% of decisions are rendered at the time of the request or within one hour of the request. 98% receive medical necessity determinations within 3 business days.

CT was among the first states in the nation to implement an independent, third-party, external appeal mechanism for both consumers and providers. Questions of medical necessity dispute are forwarded through the Department of Insurance to an outside entity made up of physicians within that particular specialty area. The Independent Review Organization (IRO) reviews all the relevant information from both sides and issues a decision that is binding on both parties. The Department of Insurance reports that external appeals generally split roughly 50/50, with half being decided in favor of the provider/member and half in favor of the health plan, suggesting that the process fairly arbitrates matters of legitimate dispute.

Consider that prior authorization contemplates:

- Opioids prescribed for patients also receiving benzodiazepines.
- Medications prescribed as "off-label" for indications not approved by FDA.
- Antipsychotic medications prescribed for children and adolescents.

- Promotion of high value care in Medicare Advantage and Part D plans.
- Best price and quality for durable medical equipment in Medicare FFS.
- Evidence-based guidelines for diagnostic imaging in Medicare FFS

The value of medical management is widely recognized in numerous federal and state government-sponsored programs like Medicare and Medicaid just like in the commercial market. The health insurance industry would welcome the opportunity to work with the study committee envisioned under this legislation or any other working group to discuss matters related to “gold carding” and prior authorization.

Thank you for your consideration.